

Let's Get Washington Covered Task Force
Options Relating to Utilization of Health Services
Task Force Meeting, November 19, 2003

Introduction

The rising cost of health services is a concern for sustaining enrollment in health insurance. The cost of mandated services is identified in the literature and by some task force members as a potential driver of health expenditures. Inappropriate use of health services, underuse and overuse, and the need for evidence and standards to promote more appropriate utilization of health services is another potential driver of health expenditures.

The appropriate use of health services is one solution that can lead to more affordable and sustainable health insurance. The task force shows an interest in how statutory or regulatory changes might promote the use of evidence-based care and better utilization management. Any improvement to the framework that governs the coverage of benefits and the use of benefits can promote better management and utilization of health care services.

The Stanford University Center for Health Policy and the Institute of Medicine are leaders in researching and promoting *medically necessary* care, based on *effective* and *clinically efficacious* practices.

Medical Necessity

The Stanford University Center for Health Policy is the source of model contract language for medical necessity. Basic Health Plan contracts and rules being developed by the Medical Assistance Administration (Medicaid/DSHS) on medical necessity are similar to Stanford University's model language. The definition of medical necessity from the Basic Health contract is copied for your reference:

A service is "medically necessary" if it is recommended by your treating provider and your health plan's Medical Director or provider designee and if all of the following conditions are met:

1. The purpose of the service, supply or intervention is to treat a medical condition;
2. It is the most appropriate level of service, supply or intervention considering the potential benefits and harm to the patient;
3. The level of service, supply or intervention is known to be effective in improving health outcomes;
4. The level of service, supply or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and
5. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

The basis of the Basic Health Plan contracts and Medical Assistance Administration rules is the passage of HB 1299, an act relating to evidenced-based health services for state-purchased care. The bill calls for a common definition of medical necessity based, to the extent possible, upon the best scientific and medical evidence.

Effectiveness and Clinically Efficacious Services

The Institute of Medicine's research in *Crossing the Quality Chasm* supplies Basic Health and Medical Assistance Administration with definitions of effectiveness, scientific evidence, etc. that help to define medical necessity. For example, Basic Health and Medical Assistance Administration borrowed from the Institute of Medicine to craft the following definition of *effective* for use in both public programs.

“Effective” means that the intervention, supply or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

Following Stanford University and the Institute of Medicine, Basic Health and Medical Assistance Administration promote the importance of and define cost-effective or clinically efficacious services.

Evidence-Based Care

Effective care implies care based on evidence. Stanford University and the Institute of Medicine promote evidence-based care as the route to achieving effectiveness. Their definitions are not unrealistic and can exist in the real world. They take into account that all services cannot be held to the highest standards of clinical studies. The definition of *evidence* requires scientific knowledge or some level of acceptable studies, experiments, standards, or causal relationships. Medical Assistance Administration is proposing a rule that contains this definition:

“**Evidence**” means known to be effective in improving health outcomes. For new health care services, effectiveness is determined by scientific evidence. For existing health care services, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

Recommendations from the Office of Insurance Commissioner

Private health carriers in Washington State are leaders in applying the concepts of medical necessity and evidence-based care. Group Health Cooperative is also a source of research in this area and contributes to the work of the Institute of Medicine. The examples shown above demonstrate how public health care programs are using legal means (contracts, laws, and rules) to support and promote medical necessity and evidence-based care. The laws and rules on medical necessity that govern the private sector are “behind the curve.” They are not promoting recent research to improve the practice of health care. A few examples of the current laws for private health insurance are listed below, along with some recommended options for discussion at the November 19, 2003 task force meeting.

I. EVERY CATEGORY OF PROVIDER:

Under RCW 48.43.045, carriers must permit every category of provider to provide health care services if they agree to abide by standards that relate to cost-effective and clinically efficacious health services. Determination of cost-effectiveness or clinical efficacy must be supported by evidence. In some instances, there is no clinical or scientific evidence available to either support or refute whether a particular category of provider can render cost-effective or clinically efficacious services for certain conditions.

II. MEDICAL NECESSITY:

Title 48 RCW contains references to “medical necessity” for the purpose of determining if services are appropriate but does not include a specifically defined standard.

III. POSSIBLE OPTIONS:

- A. Should RCW 48.43.045 be amended to permit carriers to deny coverage if there is no clinical or scientific evidence to support whether or not a particular service is cost-effective or clinically efficacious?
- B. Should Title 48 RCW be amended to include a framework for “medical necessity” consistent with standards that are being developed across state purchased health care programs for use by carriers in determining if treatment or services are appropriate?
- C. Should the framework for “medical necessity” be in addition to or in lieu of cost-effectiveness or clinical efficacy?